**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

NORTHWEST TEXAS HOSPITAL
1201 LAKE WOODLANDS DR STE 4024
WOODLANDS TX 77380

**Respondent Name**
Texas Mutual Insurance Co

**Carrier's Austin Representative Box**
Box Number 54

**MFDR Tracking Number**
M4-12-3465-01

**MFDR Date Received**
July 27, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "In the present matter, the Claimant was suffering from a recent onset of ROTATOR CUFF STRAIN."

**Amount in Dispute:** $652.48

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Because the documentation does not substantiate a medical emergency consistent with the definition of such from 133.2(a)(4), Texas Mutual declined payment."

**Response Submitted by:** Texas Mutual Insurance Co

**SUMMARY OF FINDINGS**

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| December 26, 2011 | Outpatient Hospital Services | $652.48 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines an emergency.

Explanation of benefits dated February 2, 2012
- CAC – W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

Explanation of benefits dated June 18, 2012
- CAC –W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES.
- 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

**Issues**

1. Does the disputed service(s) meet the definition of emergency services?
2. Is the requestor entitled to reimbursement?

**Findings**

1. The insurance carrier denied disputed services with reason code, 899 – "DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDACE WITH RULE 133.2". 28 Texas Administrative Code §133.2(4)(A) states that, "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily function in serious jeopardy, or (ii) serious dysfunction of any body organ or part." The medical documentation does not meet the definition of an emergency pursuant to §133.2(4)(A). For example:
    a. EMERGENCY PHYSICIAN RECORD (page 1 of 2) states, "no acute distress. "

   The Division concludes the denial code 899 is supported.
2. No reimbursement can be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | June 11, 2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.